Commonwealth of Massachusetts
Department of Public Health

Issue Briefs:

Massachusetts

Behavioral Health Analysis

Commonwealth of Massachusetts
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Integration of Behavioral Health and Primary Care

Many people have comorbid physical and behavioral health conditions and yet, until recently, the prevailing organization of our healthcare delivery system has separated behavioral health and primary care services. In Massachusetts, 17.1% of adults reported having a mental illness in the past year,[1] and the rate of mental illness was significantly higher (26.6%) among those who also had a physical health condition.[2] Similarly, 10.1% of MA adults reported substance dependence or abuse, and rates of substance use disorders were higher among those with more than one comorbid physical health condition (e.g., 13.1% of those with two comorbid health conditions, 14.0% of those with three or more).[3] Moreover, treatments for one type of disorder can exacerbate the other.[4] In general, having comorbid physical and behavioral health conditions is associated with a number of negative health outcomes, including functional impairment and decreased length and quality of life, as well as with increased health care costs.[5,6]

Despite the high prevalence of illness, relatively few physicians routinely screen for mental illness or substance use disorders. In 2006-2007 across the US, mental health screenings were conducted in only 2% of all physician office visits, although 79% of primary care practices offered mental health services onsite or by referral.[7] Across the country, many mental health and substance abuse providers are inadequately equipped to handle the increasingly complex physical health needs of their patients.[8] Indeed, both medical and mental health care providers face challenges in addressing patients' full spectrum of physical and behavioral health needs.

Care that integrates physical and behavioral health services can be an important part of the solution. Specifically, integrated care may increase the ability of medical providers to address behavioral health issues[9] and the ability of behavioral health providers to address medical issues,[10] as well as improve treatment outcomes for both mental health and substance use disorders.[11,12,13,14,15] Moreover, integrated care may have the potential to reduce healthcare costs.[16,17,18]

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1 SAMHSA, Center for Behavioral Health Statistics and Quality. *National Survey of Drug Use and Health, 2008-11 Combined and 2012.* Retrieved from http://www.samhsa.gov/data/NSDUH.aspx.

2 SAMHSA, Center for Behavioral Health Statistics and Quality. *National Survey on Drug Use and Health, 2008-2011 (revised 10/13). And 2012.* Retrieved from http://www.samhsa.gov/data/NSDUH.aspx.

3 SAMHSA, Center for Behavioral Health Statistics and Quality. *National Survey on Drug Use and Health, 2008-2011 (revised 10/13). And 2012.* Retrieved from http://www.samhsa.gov/data/NSDUH.aspx

4 Druss, B. G., & Walker, E. R. (2011). Mental disorders and medical comorbidity. *Robert Wood Johnson Foundation, The Synthesis Project*. ISSN 2155-3718. Retrieved from www.policysynthesis.org

5 Dickerson et al, 2008; Egede, 2007; Katon, 2003; Stein et al., 2006; as cited in Druss & Walker (2011)

6 Commonwealth of Massachusetts, Health Policy Commission. (2014). 2013 Cost trends report: July 2014 supplement.

7 HealthyPeople.gov. DATA2020. Retrieved from http://www.healthypeople.gov/

8 Druss, B. G. & Mauer, B. J. (2010). Health care reform and care at the behavioral health-primary care interface. *Psychiatric Services*, *61*, 1087-1092.

9 Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health*, *21*, 121-134.

10 Druss & von Esenwein (2001), as cited in Druss & Mauer (2010).

11 Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., & Lu, Y. (2001). Integrating primary medical care with addiction treatment: A randomized controlled trial. *Journal of the American Medical Association, 286*, 1715-23.

12 Friedman, P. D., Shang, Z., Hendrickson, J., Stein, M. D., & Gerstein, D. R. (2003). Effect of primary medical care on addiction and medical severity in substance abuse treatment programs. *Journal of General Internal Medicine, 18*, 1-8.

There are a number of different approaches to the integration of medical and behavioral health care, including consultation between behavioral health and medical providers,[19] collaborative care involving a care manager and/or behavioral health consultant,[20] co-location of services, and partnerships between general health care providers and behavioral health care treatment providers.[21,22] Provider selection of integrated care models should consider the needs of the patient population being served. In particular, Cherokee Health Systems in Tennessee,[23] the DIAMOND Project in Minnesota,[24] and the Collaborative Care Model[25] are often cited as examples of effective integrated care.

At the practice level, integration takes two main forms: (1) expanding the capacity of primary care practices and health clinics to treat mental health and substance abuse diagnoses and (2) bringing better physical health care to people with serious mental illness or addictions served primarily through behavioral health providers. In primary care settings, collaborative care approaches (i.e., those that use a multidisciplinary team to screen and track behavioral health conditions) and adding a mental health clinician to a practice have enhanced primary care providers' ability to treat behavioral health conditions; patients experienced a higher quality of care, had better clinical outcomes, and were more satisfied with their care.[26,27,28,29]

Among populations with more intensive behavioral health needs being served in behavioral health settings, a number of components may facilitate integrated care: regular screening and tracking of glucose and lipid levels, blood pressure, and weight/BMI as well as care managers to support

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[13] Mauer, B. J. (2009 Apr). *Behavioral health/primary care integration and the person-centered healthcare home.* Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

[14] Gilbody et al. (2006) as cited in Druss & Mauer (2010).

[15] Saitz et al. (2007) as cited in Druss & Mauer (2010).

[16] Milliman, Inc. (2014). *Economic impact of integrated medical-behavioral healthcare: Implications for Psychiatry*. Denver, CO: Melek, S. P., Norris, D. T, Paulus, J.

[17] Mauer, B. J. (2009). Behavioral health/primary care integration and the person-centered healthcare home. Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

[18] Behavioral Health Integration Task Force. (2013). Report to the legislature and the health policy commission.

[19] Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health*, *21*, 121-134.

[20] Mauer, B. J. (2009). *Behavioral health/primary care integration and the person-centered healthcare home.* Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

[21] Druss, B. G. & Mauer, B. J. (2010). Health care reform and care at the behavioral health-primary care interface. *Psychiatric Services, 61*, 1087-1092.

[22] Druss, B. G. & Walker, E. R. (2011). Mental disorders and medical comorbidity. Robert Wood Johnson Foundation, The Synthesis Project. ISSN 2155-3718. Retrieved from www.policysynthesis.org

[23] Accessed from http://www.cherokeehealth.com/

[24] Accessed from https://www.icsi.org/health_initiatives/mental_health/diamond_for_depression/

[25] Unützer, J., Harbin, H., Schoenbaum, M. & Druss, B. (2013). The Collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. *Health Home Information Resource Center Brief*. *Center for Health Care Strategies and Mathematica Policy Research.* Retrieved from http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf on 4/7/2014.

[26] Butler, et al. (2009) as cited in Druss & Walker (2011)

[27] Gilbody, et al. (2006) as cited in Druss & Walker (2011)

[28] Williams, et al. (2007) as cited in Druss & Walker (2011)

[29] Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health*, *21*, 121-134.

individuals outside of the desired range; medical nurse practitioners and/or primary care physicians located in BH facilities or available for consultation; adapting evidence-based practices for medical conditions for use in the behavioral health system; and engagement of individuals in managing their health conditions, with peers serving as group facilitators.[30,31] Provision of primary care in methadone treatment settings was found to result in reductions in the number of emergency visits and acute hospitalizations for patients receiving both continuous methadone treatment and at least two primary care visits in comparison to other patients.[32]

Co-locating behavioral health and primary care services can greatly increase access to care.[33] Thus, integration will likely increase the capacity of both the medical and behavioral health systems to serve the needs of those with or at risk for comorbid physical and behavioral health conditions. The clinical integration of medical and behavioral health care must be a collaborative effort, supported by financing and infrastructure (including policy, licensure, regulation, workforce, and information sharing).[34]

To this end, many initiatives in the state are working to improve integration of behavioral health with primary care. Chapter 224 established a Behavioral Health Integration Task Force that developed a number of recommendations and actions to advance integration. In addition, MassHealth's Primary Care Payment Reform promotes integration of services, including through a capitated payment to primary care providers for primary care and some behavioral health services. Furthermore, the FY15 General Appropriations Act includes $2 million for a behavioral health integration initiative, administered by the Health Policy Commission. BSAS has also provided assistance to help providers enhance their ability to identify and address substance abuse issues among their patients by training staff to conduct screening, brief intervention, and referral to treatment (SBIRT). SBIRT is an evidence-based public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders. BSAS provides technical assistance and training for the adoption of this model for hospital emergency rooms, school nurses, and other settings.

In addition, BSAS is working with the DPH Division of Health Quality to facilitate licensure of primary care clinics in substance abuse treatment settings and substance abuse clinic licenses in Federally Qualified Health Centers. Health information technology (e.g., electronic medical records)

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[30] Mauer, B. J. (2009 Apr). Behavioral health/primary care integration and the person-centered healthcare home. Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

[31] Commonwealth of Massachusetts, Health Policy Commission. (2014). 2013 Cost trends report: July 2014 supplement.

[32] Gourevitch, M. N., et al. (2007). On-site medical care in methadone maintenance: associations with health care use and expenditures on-site medical care in methadone maintenance: Associations with health care use and expenditures. *Journal of Substance Abuse Treatment, 32*, 2 143-51.

[33] Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health, 21,* 121-134.

[34] Mauer, B. J. (2009). Behavioral health/primary care integration and the person-centered healthcare home. *National Council for Community Behavioral Healthcare.* Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

may facilitate quality improvement and more integrated services,[35] and it will be important to balance confidentiality protections with the desire to ensure communication among providers for coordination of treatment goals and continuity of care. [36,37]

The Health Planning Council and the Commonwealth of Massachusetts have an extraordinary opportunity to increase the delivery of integrated care.

[35] Druss, B. G. & Mauer, B. J. (2010). Health care reform and care at the behavioral health-primary care interface. *Psychiatric Services*, *61,* 1087-1092.

[36] Shortell, et al. (2000) as cited in Druss & Mauer (2010)

[37] Mauer, B. J. (2009). Behavioral health/primary care integration and the person-centered healthcare home. *National Council for Community Behavioral Healthcare.* Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf